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**MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

05937

**CERTIFICATE OF DEATH**

05934

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**Page 4 may be retained by the hospital or attending physician.**  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		Somerset MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield		c. LENGTH OF STAY IN 1b 1 Day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield, Maryland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) McCready Memorial Hospital				d. STREET ADDRESS Traillor 10, Landon Point	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First Infant	Middle Female	Last Brock	4. DATE OF DEATH Apr. 17 1966 Day Year 19 66
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 16, 1966	9. AGE (In years last birthday) No. yrs. No
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (County & State, or foreign country) Crisfield, Maryland	
13. FATHER'S NAME Robert E. Brock		14. MOTHER'S MAIDEN NAME Martha Baine		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Robert E. Brock, Same as 2. abcd	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Abdomen -</i> <i>7625</i>					
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause first.		DUE TO (b) <i>Caesarean Section, mother because</i>			
		DUE TO (c) <i>Severe vag. and infection -</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on 4/17/66 19_____, and that death occurred at 5:20 P.M. from the causes and on the date stated above.					
22a. SIGNATURE <i>S. M. Peyton</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) S. M. Peyton, M.D.		22d. ADDRESS Crisfield, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF April 18, 1966	23c. NAME OF CEMETERY OR CREMATORIAL St. Peter's Cemetery	23d. LOCATION (City, town or county) Crisfield, Maryland (State)	
24. FUNERAL DIRECTOR Bradshaw & Sons, Crisfield, Maryland		ADDRESS		25a. REC'D BY REGISTRAR APR 20 1966	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



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M

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

05938

**CERTIFICATE OF DEATH**

05935

1. PLACE OF DEATH  
a. COUNTY

Somerset

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Crisfield

c. LENGTH OF STAY IN lb

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

McCready Memorial Hospital

3. NAME OF  
DECEASED  
(Type or print)First  
Lake

Middle

Last  
Conner4. DATE  
OF  
DEATHMonth  
Apr.Day  
30Year  
19665. SEX  
Male6. COLOR OR RACE  
White7. MARRIED  NEVER MARRIED   
WIDOWED  DIVORCED 8. DATE OF BIRTH  
Nov. 1, 18969. AGE (In years  
last birthday)  
69 yrs.10. IF UNDER 1 YEAR  
Months  
Days11. IF UNDER 24 HRS.  
Hours  
Min.10a. USUAL OCCUPATION (Give kind of work done  
during most of working life, even if retired)

Foreman

10b. KIND OF BUSINESS OR  
INDUSTRY

County Roads Comm.

11. BIRTHPLACE (County &amp; State, or foreign country)

Marion Station, Md.

12. CITIZEN OF WHAT  
COUNTRY?  
U.S.A.

13. FATHER'S NAME

Joseph W. Conner

14. MOTHER'S MAIDEN NAME

Drucilla Corbin

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or Unknown) (If yes give war or dates of service)

No

16. SOCIAL SECURITY NO.

220-32-1598

17. INFORMANT

Mrs. Lucille Conner, same as 2,a.b.c.d.

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)Arterio Sclerotic and Arterio. Heart block, Card. by they  
Conditions, If any, which  
gave rise to Immediate  
cause (a), stating the  
underlying cause last.

DUE TO

(b)

DUE TO

(c)

V. Myrtle.

INTERVAL BETWEEN  
ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY  
PERFORMED?YES  NO 20a. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year  
Hour a.m. 19  
p.m.20d. INJURY OCCURRED  
While at work  Not While at work 20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1-20, 1966 to 4-30, 1966, that (I) (we) last  
saw the deceased alive on 4/30/66 19\_\_\_\_\_, and that death occurred at \_\_\_\_\_, from the causes and on the date stated above.

22a. SIGNATURE

Dorothy E. Coulbourn

22b. DATE SIGNED

22c. PHYSICIAN'S  
NAME (Type)

G. C. Coulbourn, M.D.

M.D. ATTENDING PHYS.  MED. DIRECTOR  STAFF PHYS. 

22d. ADDRESS

Crisfield, Maryland

23a. BURIAL, CREMATION,  
REMOVAL (Specify)

23b. DATE THEREOF

23c. NAME OF CEMETERY OR CREMATORIUM

23d. LOCATION (City, town or county) (State)

Burial

May 3, 1966

St. Paul's Cemetery

Marion Station, Md.

24. FUNERAL DIRECTOR

ADDRESS

25a. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

Bradshaw &amp; Sons — Crisfield, Md.

DATE MAY 5 1966

Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2, and any event, within 72 hours after death.



1 M

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

05939

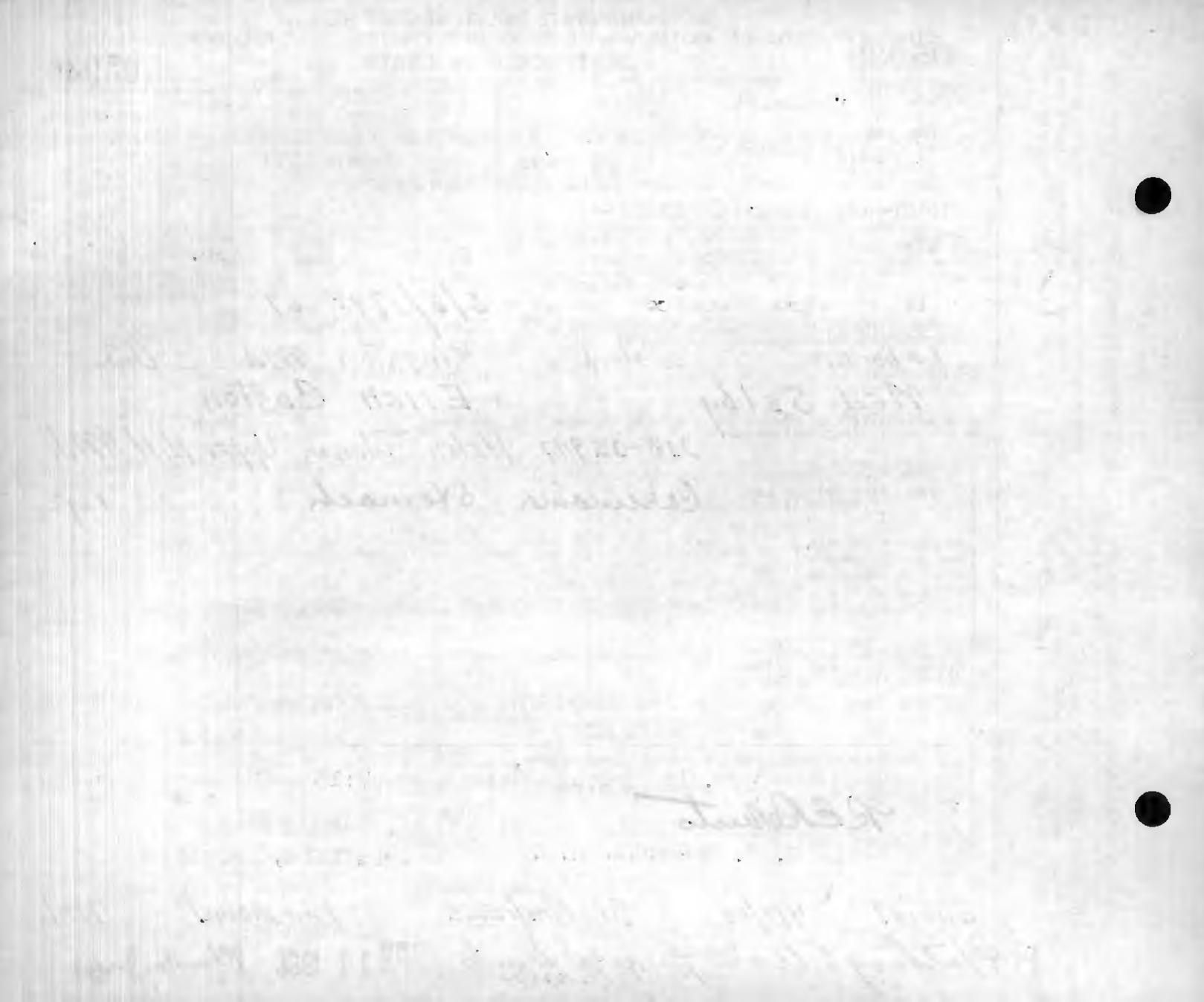
05936

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Somerset		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield		c. LENGTH OF STAY IN 1b 25 Days		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland		b. COUNTY Somerset		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) McCready Memorial Hospital						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Hill		19. 1		
3. NAME OF DECEASED (Type or print)		First Blanche	Middle 	Last Handy	4. DATE OF DEATH Apr. 4 1966	Month Apr.	Day 4	Year 1966	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Female		6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/6/1898	9. AGE (In years last birthday) 67 yrs.	10. IF UNDER 1 YEAR Months 	11. IF UNDER 24 HRS Days 	12. IF UNDER 24 HRS Hours 	13. IF UNDER 24 HRS Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Seafood		11. BIRTHPLACE (County & State, or foreign country) Kingston Md.		12. CITIZEN OF WHAT COUNTRY? U.S.				
13. FATHER'S NAME Ned Selby		14. MOTHER'S MAIDEN NAME Eileen Coston		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) 		16. SOCIAL SECURITY NO. 218-33-9117		17. INFORMANT Address Helen Johnson Upper Hill Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 151X		Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Cerebral Sclerosis				INTERVAL BETWEEN ONSET AND DEATH 142.		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 	20f. (City or town) 	(County) 	(State) 
21. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on Apr. 4 1966, and that death occurred at 7:15 pm from the causes and on the date stated above.		22a. SIGNATURE R.E. Roberts		22b. DATE SIGNED 						
22c. PHYSICIAN'S NAME (Type) R. E. Roberts, M.D.		M.D. ATTENDING PHYS. <input type="checkbox"/> M.D. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22d. ADDRESS Crisfield, Maryland						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/9/66		23c. NAME OF CEMETERY OR CREMATORIAL ST. Andrews		23d. LOCATION (City, town or county) Fairmount		(State) Md.		
24. FUNERAL DIRECTOR Anthony G. Ward Funeral Director Crisfield MD.		ADDRESS 		25a. REC'D BY REGISTRAR FBI 11 1966		25b. REGISTRAR'S SIGNATURE Charles Judge				



FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05940

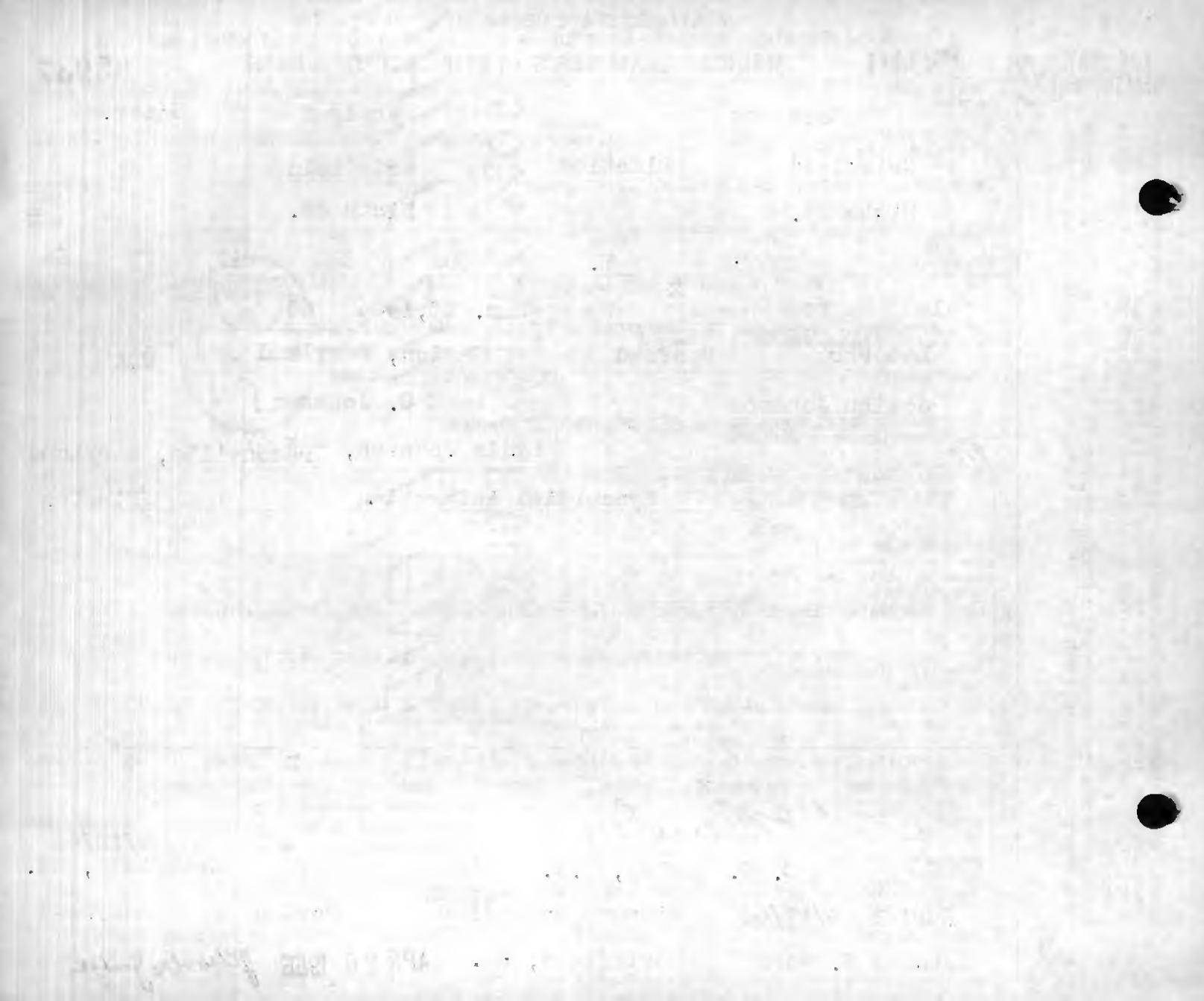
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05937

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1, 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1		6		16		1		16		1		16	
FOR STATE HEALTH DEPT.		M		Somerset		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)		3. PLACE OF DEATH a. COUNTY			
								b. STATE Maryland		b. COUNTY Somerset			
								c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					
				Crisfield		Lifetime		Crisfield		19-1			
				d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM?			
				Ninth St.				Ninth St.		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First WEBSTER		Middle T.		Last JOHNSON		4. DATE OF DEATH April		Month 13		Day 19 Year 66	
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH Mar. 15, 1906		9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR Months		IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Seafood		11. BIRTHPLACE (State or foreign country) Marion, Maryland		12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Josiah Johnson		14. MOTHER'S MAIDEN NAME Anna B. Johnson											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Lydia Johnson, Box 67 Grasonville, Maryland		Address							
18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		DUE TO Myocardial infarction						INTERVAL BETWEEN ONSET AND DEATH Minutes					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)													
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <i>C. G. Rawley</i>		EXAMINER'S NAME (Type) C. G. Rawley, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED 4/18/66			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/17/66		23c. NAME OF CEMETERY OR CREMATORIUM Library Methodist		23d. LOCATION (City, town or county) Marion		(State) Maryland					
24. FUNERAL DIRECTOR Anthony E. Ward		ADDRESS Crisfield, Md.		25a. REC'D BY REGISTRAR APR 20 1966		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>							
VR AISM (5 5M 1/65)													



FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05941 05938

To DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

To FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Somerset</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Somerset</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Westover</b>		c. LENGTH OF STAY IN 1b <b>17 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Westover</b>		d. STREET ADDRESS ---		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ---				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>OLIVER HERMAN KING</b>		First	Middle	Last	4. DATE OF DEATH <b>April 8 1966</b>	Month	Day	Year
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 2, 1902</b>	9. AGE (In years last birthday) <b>64 yrs.</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>		11. BIRTHPLACE (State or foreign country) <b>Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Elmer King</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Elizabeth Blank</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>279-22-6181</b>		17. INFORMANT <b>Mrs Genevieve King, Westover, Md.</b>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Generalized lymphosarcoma INTERVAL BETWEEN ONSET AND DEATH <b>2yrs</b>						
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. <b>2001</b>		DUE TO (b) DUE TO (c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b)								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>Everett Sutter</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>						
EXAMINER'S NAME (Type) <b>Everett Sutter MD</b>		22. DATE SIGNED <b>4-9-66</b>						
Address (Street, city, town, or county) <b>Somerset</b>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4-10-1966</b>		23c. NAME OF CEMETERY OR CREMATORIUM <b>Holly Grove Mennonite</b>		23d. LOCATION (City, town or county) (State) <b>Somerset County, Md.</b>		
24. FUNERAL DIRECTOR <i>Robert H. Watson</i>		ADDRESS <b>Pocomoke City, Md.</b>		25a. REC'D BY REGISTRAR <b>APR 11 1966</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

1960-1961

2

1960-1961

1960-1961

1960-1961

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 115030

1. PLACE OF DEATH a. COUNTY <i>Somerset</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <i>Md</i>		b. COUNTY <i>Somerset</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Marion</i>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Nation</i>		d. STREET ADDRESS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>None</i>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Senneha</i>		First <i>G.</i>	Middle <i>Logan</i>	Last <i>Logan</i>	4. DATE OF DEATH Month <i>April</i>	Day <i>11</i>	Year <i>1966</i>		
5. SEX <i>Female</i>		6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 14, 1876</i>	9. AGE (In years last birthday) <i>89 yrs.</i>	10. IF UNDER 1 YEAR Months <i>10</i>	11. IF UNDER 24 HRS Days <i>28</i>	Hours <i>0</i>	Min <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Hopewell</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Alfred Miles</i>		14. MOTHER'S MAIDEN NAME <i>Sabre Johnson</i>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No.</i>		16. SOCIAL SECURITY NO <i>23-14-7302</i>		17. INFORMANT <i>Mrs. Hazel Croswell - Ft. 1 Box 361</i>		Address <i>Marietta Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a).									
422.1		DUE TO		<i>Acute dilatation in art</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 hr.</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first <i>Myocarditis chronic</i>		(b)		<i>Myocarditis chronic</i>		yrs -			
DUE TO		(c)		<i>Gen'l arterio sclerosis - Senility</i>		yrs -			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month Day Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
19									
21. I certify that I attended the deceased from <u>11/17/46</u> , 19 <u>66</u> , to <u>Apr. 7</u> , 19 <u>66</u> , that I last saw the deceased alive on <u>Apr. 7</u> , 19 <u>66</u> , and that death occurred at <u>6:30 AM</u> , from the causes and on the date stated above.									
ADDRESS (Street, city or town, state) <i>Crisfield, Maryland</i>									
DATE SIGNED <i>4/12/66</i>									
ACTUAL SIGNATURE <i>C. G. Rawley</i>		M.D.		324 Main St.					
PHYSICIAN'S NAME (Type) <i>C. G. Rawley, M.D.</i>		Crisfield, Maryland							
22a. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>April 14, 1966</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Wesley</i>		22d. LOCATION (City, town, or county) <i>Marion Sta., Md. Som. Co.</i>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Charles H. Rawley</i>		ADDRESS <i>1st Ward Marion Sta., Md.</i>		24a. REC'D. BY REGISTRAR DATE <i>APR 14 1966</i>		24b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by hospital or attending physician.  
**TO FUNERAL DIRECTOR:** This certificate has been signed by the attending physician and completely filled in before being filed with the registrar. If this certificate has been signed by the attending physician and completely filled in before being filed with the registrar, this certificate may be used as the burial/transit permit. Then please move carbon papers. Pages 1 and 2 will be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

M

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

05941

1. PLACE OF DEATH a. COUNTY <b>Somerset</b>		2. USUAL RESIDENCE [Where deceased lived, if institution, residence before admission] a. STATE <b>Md.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westover</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westover, Md., Rt. 1 #193</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Estella</b>		First <b>Estella</b>	Middle <b></b>
4. DATE OF DEATH <b>April 21 1966</b>		Last <b>Maddox</b>	Month <b>April</b> Day <b>21</b> Year <b>1966</b>
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>Dec. 18, 1886</b>		9. AGE (In years last birthday) <b>79</b> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b></b>	
10c. BIRTHPLACE (State or foreign country) <b>Westover, Som.-Co.</b>		11. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Noah Collins</b>		14. MOTHER'S MAIDEN NAME <b>Nancy Ballard</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <b>No.</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Ida Collins-Westover, Md. Rt. 1 #193</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Bronchitis</b>		2 years	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Exposure to Cold</b>			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Arthritis</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Name, form, factory, street, office bldg., etc.)		20f. (City or town) <b>Westover</b> (County) <b>Somerset</b> (State) <b>Md.</b>	
21. I certify that I attended the deceased from <b>Feb 10, 1965</b> to <b>Apr 12, 1966</b> , that I last saw the deceased alive on <b>Apr 18, 1965</b> , and that death occurred at <b>6:30 AM</b> , from the causes and on the date stated above. ACTUAL SIGNATURE <b>Evelyn J. Johnson, M.D.</b> PHYSICIAN'S NAME (Type) <b></b>		ADDRESS (Street, city or town, state) <b>Princess Anne, Md.</b> DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>APP. 24-66 St. James Cemetery</b>		22b. DATE THEREOF <b>Westover, Som.-Co., Md.</b> (State)	
22c. LOCATION (City, town, or county) <b>Westover, Som.-Co., Md.</b>		22d. NAME OF CEMETERY OR CREMATORIUM	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles H. Ward-Marion Star, Md.</b>		ADDRESS <b></b>	24a. REC'D BY REGISTRAR <b>APR 25 1966</b>
		DATE <b>APR 25 1966</b>	24b. REGISTRAR'S SIGNATURE <b>Charles H. Ward-Marion Star, Md.</b>



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please, remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and, in any event, within 72 hours after death.

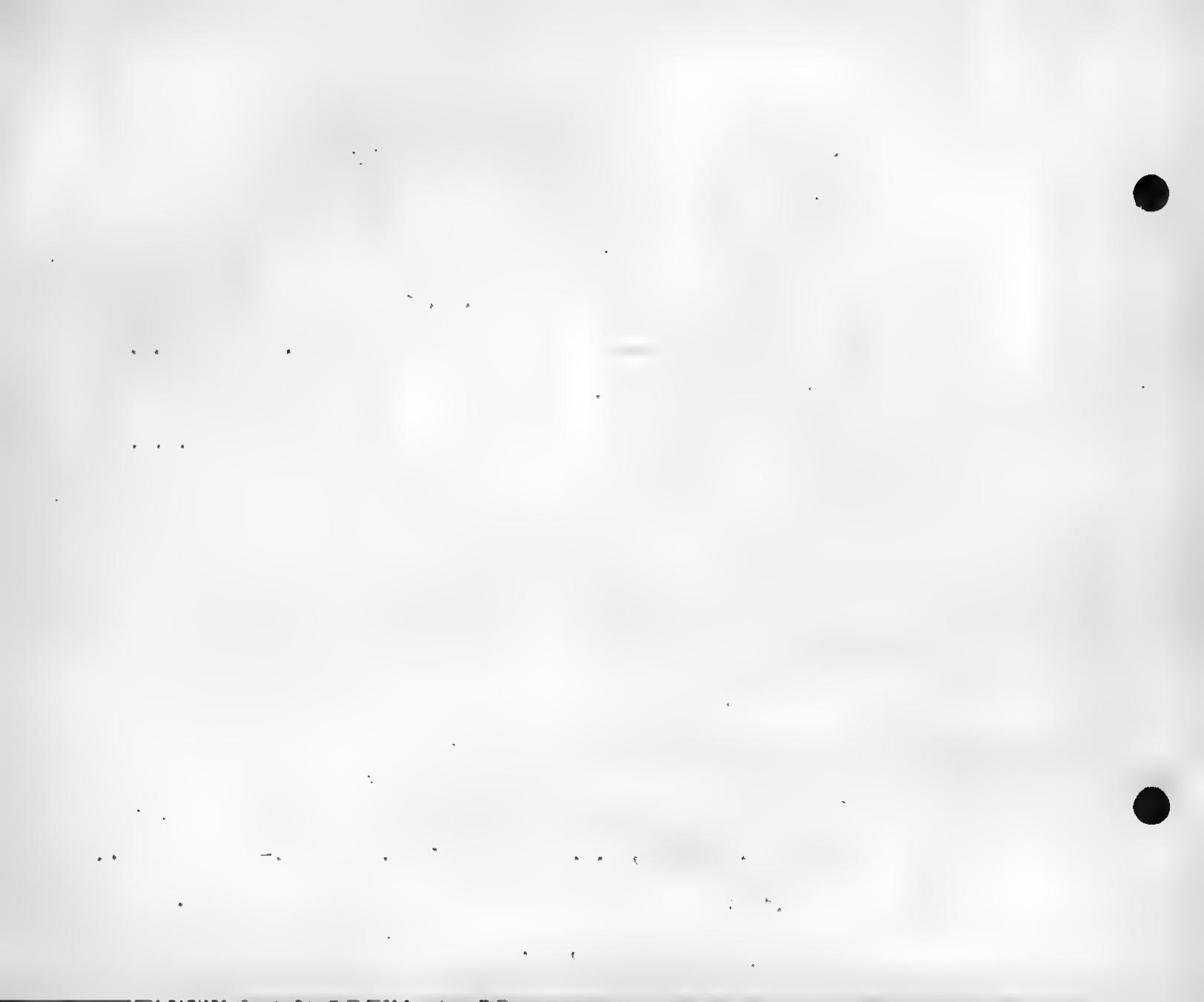
**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

**05941**

**CERTIFICATE OF DEATH**

**05941**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE	
Somerset MARYLAND		Maryland b. COUNTY	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Crisfield		c. LENGTH OF STAY IN 1b Lifetime	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Mariners Section		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First SADIE	Middle FONZY	Last OUTTEN
4. DATE OF DEATH	Month April	Day 12	Year 19 66
5. SEX	6. COLOR OR RACE Female White	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH	9. AGE (In years last birthday) Dec. 4, 1910 55 yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (County & State, or foreign country) Deal Island, Md.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Milbourne Elliott, Sr.	14. MOTHER'S MAIDEN NAME Fannie Crockett		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO.	17. INFORMANT Maurice Outten, same as 2 a.b.c.d. above	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Infarct</i>			
Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) (c)			
DUE TO (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
INTERVAL BETWEEN ONSET AND DEATH 1 day			
MEDICAL CERTIFICATION			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1964</u> , 19, to <u>4/11</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>4/11</u> , 19 <u>66</u> and that death occurred at <u>6 AM</u> , from the causes and on the date stated above.		22b. DATE SIGNED <u>4/12/66</u>	
22a. SIGNATURE <i>RE Roberts</i>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) Robert E. Roberts, M.D.		22d. ADDRESS 512 W. Main St.-Crisfield, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Apr. 15, 1966	23c. NAME OF CEMETERY OR CREMATORIAL Sunnyridge Memorial Park
24. FUNERAL DIRECTOR		ADDRESS Bradshaw & Sons--Crisfield, Md.	25a. REC'D BY REGISTRAR APR 20 1966
			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be retained by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05945

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Somerset</b>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Crisfield</b>		c. LENGTH OF STAY IN 1b <b>Lifetime</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Sackertown Rd.</b>		e. STREET ADDRESS <b>Sackertown Rd.</b>	
3. NAME OF DECEASED (Type or print) <b>CLARENCE COCHRANE RIGGIN</b>		6. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
4. DATE OF DEATH <b>April 23,</b>		5. SEX Male	
6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>Aug. 23, 1891</b>		9. AGE (in years last birthday) <b>74 yrs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Dealer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retail Seafood</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Crisfield, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>D. Qui nn Riggan</b>		14. MOTHER'S MAIDEN NAME <b>Mariah Sterling</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-14-9676</b>	
17. INFORMANT <b>Mrs. Mildred W. Riggan, Same as 2, abcm above</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary Edema</i> DUE TO (b) <i>Right Side Heart Failure</i> DUE TO (c) <i>Emphysema : Severe</i>			
INTERVAL BETWEEN ONSET AND DEATH <i>24 hr.</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
3 gr.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour s.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>July</i> , 19 <i>63</i> , to <i>4/22</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>4/22</i> 19 <i>66</i> and that death occurred at <i>3:30 AM</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>Robert E Roberts</i>			
22b. DATE SIGNED <i>4/23/66</i>			
22c. PHYSICIAN'S NAME (Type) <b>Robert E. Roberts, M.D.</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <b>Crisfield, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Apr. 26, 1966</b>	
23c. NAME OF CEMETERY OR CREMATORIUM <b>Sunnyridge Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Crisfield, Md.</b>	
24. FUNERAL DIRECTOR <b>Bradshaw &amp; Sons-- Crisfield, Md.</b>		ADDRESS	
		25a. REC'D BY REGISTRAR <b>APR 28 1966</b>	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



1 M

FOR STATE  
HEALTH DEPT.MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05946

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05946

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY  Somerset MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE Maryland b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield 19 - 1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) (DOA) McCready Memorial Hospital		d. STREET ADDRESS 136 S. 4th Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) WILLIE		First J.	Middle SMITH
4. DATE OF DEATH Apr. 4 1966	Month Day Year	5. SEX Male	6. COLOR OR RACE Negro
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH May 28, 1899	9. AGE (In years last birthday) 66 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Seafood	
11. BIRTHPLACE (State or foreign country) Brundidge, Alabama		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Willie Smith		14. MOTHER'S MAIDEN NAME Fanny Smith	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 17. INFORMANT Beatrice Lankford Address Same as 2 a.b.c.d.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction INTERVAL BETWEEN ONSET AND DEATH minutes 4 DUE TO Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>C. G. Rawley</i> CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) C. G. Rawley, M. D. M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Crisfield, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/10/66	23c. NAME OF CEMETERY OR CREMATORIAL Asbury Cemetery
23d. LOCATION (City, town or county) Crisfield		(State) Md.	
24. FUNERAL DIRECTOR Anthony E. Ward		ADDRESS Crisfield, Md.	25a. REC'D BY REGISTRAR DATE APR 11 1966
			25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>



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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05947

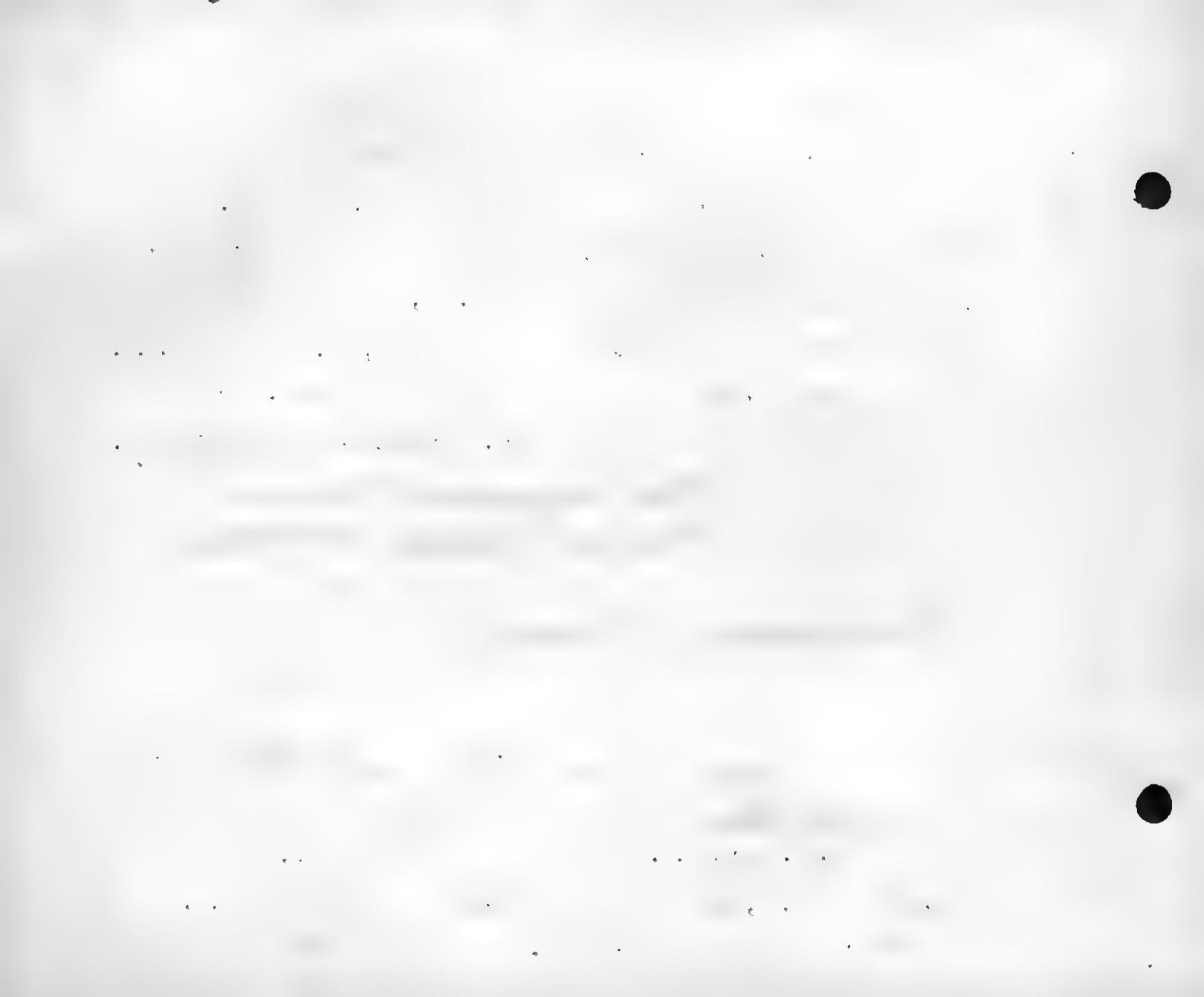
**CERTIFICATE OF DEATH**

05944

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**Page 4 may be retained by the hospital or attending physician.**  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1.		PLACE OF DEATH a. COUNTY		Somerset		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)		
		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		Crisfield		c. LENGTH OF STAY IN 1b		a. STATE Maryland		
						Lifetime		b. COUNTY Somerset		
		d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		Jacksonville Rd.				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Crisfield		
								d. STREET ADDRESS Jacksonville Rd.		
		3. NAME OF DECEASED (Type or print)		First OTIS	Middle CLINTON	Last WARD	4. DATE OF DEATH April 11 1966	Month	Day	Year
		5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 16, 1917	9. AGE (In years last birthday) 49 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours Min.
		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retail Dealer		10b. KIND OF BUSINESS OR INDUSTRY Seafood		11. GIRTHPLACE (County & State, or foreign country) Crisfield, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
		13. FATHER'S NAME Murray E. Ward		14. MOTHER'S MAIDEN NAME Blanche O. Ward						
		15. WAS DECEASED EVER IN U.S. ARMED FORCES? No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Lorraine Ward-Jacksonville Rd.- Crisfield, Md.		Address		
MEDICAL CERTIFICATION		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Toxic Myoendocarditis + Uremia</i> <i>151X</i> Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) <i>Carcinoma of Stomach + Metastasis</i> (c)					INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i> <i>I know</i> <i>6 weeks</i>	
		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Bronchitis - 6 year</i>						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
19										
21. I certify that (I) (this hospital) attended the deceased from <i>Feb.</i> , 1966, to <i>April 11</i> , 1966, that (I) (we) last saw the deceased alive on <i>April 8</i> , 1966, and that death occurred at <i>6 a.m.</i> M, from the causes and on the date stated above.								22b. DATE SIGNED <i>4/12/66</i>		
22a. SIGNATURE <i>A. N. Barr</i>										
22c. PHYSICIAN'S NAME (Type) A. N. Barr, M.D.				M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22d. ADDRESS <i>Crisfield, Md.</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Apr. 13, 1966		23c. NAME OF CEMETERY OR CREMATORIAL Sunnyridge Cemetery		23d. LOCATION (City, town or county) (State) Crisfield, Md.				
24. FUNERAL DIRECTOR Bradshaw & Sons-- Crisfield, Md.		ADDRESS				25a. REC'D. BY REGISTRAR APR 18 1966		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		
						DATE				



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FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05948

05945

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 1c. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Part I and Part III. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Somerset</b>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Princess Anne</b>		b. COUNTY <b>Somerset</b>	
c. LENGTH OF STAY IN b <b>Life time</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Princess Anne</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		19-1	
3. NAME OF DECEASED (Type or print) <b>Joseph</b>		First <b>R</b>	Middle <b>Waters</b>
4. DATE OF DEATH <b>4-14-66</b>		Month <b>4</b>	Day <b>14</b>
5. SEX <b>male</b>		6. COLOR OR RACE <b>col</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>11-15-91</b>		9. AGE (In years last birthday) <b>74</b> yrs.	10. IF UNDER 1 YEAR Months <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Tailer</b>	11. BIRTHPLACE (State or foreign country) <b>Princess Anne, Md.</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Alford Waters</b>	
14. MOTHER'S MAIDEN NAME <b>Rosa Banks</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give year or date of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH minutes	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b>		4201	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) (c)		DUE TO	
DUE TO		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
ACTUAL SIGNATURE <i>Everett Sutter</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Everett Sutter MD</b>		DATE SIGNED <b>4-18-66</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-18-66</b>	22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>John Wesley</b>
23. FUNERAL DIRECTOR <b>William H James Jr Princess Anne, Md.</b>		24a. REC'D BY REGISTRAR <b>Charles Judge</b>	24b. REGISTRAR'S SIGNATURE



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

**CERTIFICATE OF DEATH**

05949 05946

1. PLACE OF DEATH a. COUNTY Somerset MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Crisfield		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Edw. W. McCready Memorial Hosp.		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Crisfield	
d. STREET ADDRESS 112 Locust St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN Middle E. Last Wilson		4. DATE OF DEATH Month April Day 8 Year 1966	
5. SEX Male 6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH March 7, 1901		9. AGE (in years last birthday) 65 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance		10b. KIND OF BUSINESS OR INDUSTRY City of Crisfield	
11. BIRTHPLACE (County & State, or foreign country) Somerset - Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Harry Wilson		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 17. INFORMANT Mrs. Helen Wilson, Crisfield, Md.	
Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X		Cerebral Hemorrhage	
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b) _____ DUE TO (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH 1 day	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 8, 1966, and saw the deceased alive on April 8, 1966, and that death occurred at 5:20 P.M. from the causes and on the date stated above.		22. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
22a. SIGNATURE R. E. Roberts		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) R. E. Roberts, M.D.		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22d. ADDRESS Crisfield, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Apr. 11, 1966	
23c. NAME OF CEMETERY OR CREMATORIUM Crisfield Cemetery		23d. LOCATION (City, town or county) (State) Crisfield, Md.	
24. FUNERAL DIRECTOR Bradshaw & Sons — Crisfield, Md.		25a. REC'D BY REGISTRAR APR 14 1966	
ADDRESS		25b. REGISTRAR'S SIGNATURE Charles Judge	

Continued

20. Type of disease: Acute Chronic Recurrent  
Severity: Mild Severe Very Severe  
Duration: Short Medium Long

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1. Diarrhoea Abdominal bloating Constipation Gas  
2. Stomach pain Heartburn Breathlessness Loss of appetite  
3. Weight loss Swelling of hands & feet